# Sylmar Medical Center, 14124 Foothill Blvd, Suite 100, Sylmar, CA 91342

## Comprehensive Patient History Form

Patient Name:_____ DOB:_____ Today's Date: _____

Describe your main problem _____

Where is your problem located?_____

How severe is your problem? _____

Rate the severity of the problem: Mild > 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 < Severe

How long have you had this problem?_____

When does this problem occur?_____

Can you attribute the cause of this problem to anything? _____

_____

Are there other symptoms associated with the problem? _____

_____

_____

What makes this problem worse or better? _____

Have you ever had the following?

| | | |
|---|---|---|
| Diabetes……. | yes | no |
| Hypertension……. | yes | no |
| Cancer…… | yes | no |
| Stroke……. | yes | no |
| Heart trouble…….. | yes | no |
| Arthritis/gout……. | yes | no |
| Convulsions…… | yes | no |
| Bleeding tendency…….. | yes | no |
| Acute infections…….. | yes | no |
| Venereal disease……. | yes | no |
| STD's……. | yes | no |
| Hereditary defects…….. | yes | no |

List previous hospitalizations/Surgeries/Serious Injuries — When?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**What Medications are you taking?**

**N/A**

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

9)_____

10)_____

11)_____

12) _____

Patient Social History ❑ Noncontributory

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of alcohol: ❑ Never ❑ Rarely ❑ Socially ❑ Daily _____

Use of tobacco: ❑ Never ❑ Previously quit ❑ Current packs per day _____

Use of Drugs: ❑ Never ❑ Type/Frequency_____

Excessive exposure at home or work to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Noise ❑ Chemicals ❑ Smoke ❑ Animal Hair

Family Medical History ❑ Noncontributory

| | Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Spouse | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**PLEASE ANSWER ALL QUESTIONS**

***Have you had any of the following during the past three months?***

**CONSTITUTIONAL**

| | | |
|---|---|---|
| Good general health lately…….. | No | Yes |
| Recent weight change……. | No | Yes |
| Fever……... | No | Yes |
| Fatigue…… | No | Yes |
| Headaches……... | No | Yes |

**EYES**

| | | |
|---|---|---|
| Eye disease or injury…….. | No | Yes |
| Wear glasses/contact lens…….. | No | Yes |
| Blurred or double vision…… | No | Yes |
| Glaucoma……... | No | Yes |

**ENT**

| | | |
|---|---|---|
| Hearing loss……... | No | Yes |
| Ringing in the ears……. | No | Yes |
| Earaches or drainage…….. | No | Yes |
| Sinus problems……... | No | Yes |
| Nose bleeds…… | No | Yes |
| Mouth sores…… | No | Yes |
| Bleeding gums…… | No | Yes |
| Bad breath or bad taste……... | No | Yes |
| Sore throat or voice change……. | No | Yes |
| Swollen glands in neck…… | No | Yes |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| Heart trouble…… | No | Yes |
| Chest pains…….. | No | Yes |
| Sudden heart beat changes…….. | No | Yes |
| Swelling of feet, ankles or hands…… | No | Yes |

**RESPIRATORY**

| | | |
|---|---|---|
| Frequent coughing……... | No | Yes |
| Spitting up blood……. | No | Yes |
| Shortness of breath…….. | No | Yes |
| Asthma or wheezing…… | No | Yes |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| Loss of appetite…… | No | Yes |
| Change in bowel movements…….. | No | Yes |
| Nausea or vomiting……. | No | Yes |
| Frequent diarrhea……. | No | Yes |
| Painful bowel movements or constipation…….. | No | Yes |
| Blood in stool…….. | No | Yes |
| Stomach pain…… | No | Yes |

**GENITOURINARY**

| | | |
|---|---|---|
| Frequent urination…… | No | Yes |
| Burning or painful urination…… | No | Yes |
| Blood in urine…….. | No | Yes |
| Change of force of strain when urinating…… | No | Yes |
| Incontinence or dribbling……. | No | Yes |
| Kidney stones…….. | No | Yes |
| Sexual difficulty…….. | No | Yes |
| Male – testicle pain…….. | No | Yes |
| Female – pain with periods…….. | No | Yes |
| Female – irregular periods…… | No | Yes |
| Female – vaginal discharge…….. | No | Yes |

Female – # pregnancies _____ # miscarriages _____

Female – date of last pap smear _____

Female – findings of last pap smear ❑ Normal ❑ Abnormal

Date: _____

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| Joint pain…… | No | Yes |
| Joint stiffness or swelling…… | No | Yes |
| Weakness of muscles or joints…… | No | Yes |
| Muscle pain or cramps…… | No | Yes |
| Back pain……. | No | Yes |
| Cold extremities……... | No | Yes |
| Difficulty in walking…… | No | Yes |

**SKIN**

| | | |
|---|---|---|
| Rash or itching……. | No | Yes |
| Change in skin color…… | No | Yes |
| Change in hair or nails……. | No | Yes |
| Varicose veins…….. | No | Yes |
| Breast pain…… | No | Yes |
| Breast lump…….. | No | Yes |
| Breast discharge…… | No | Yes |

**NEUROLOGICAL**

| | | |
|---|---|---|
| Frequent or recurring headaches……... | No | Yes |
| Light headed or dizzy……... | No | Yes |
| Convulsions or seizures…… | No | Yes |
| Numbness or tingling sensations…….. | No | Yes |
| Tremors…… | No | Yes |
| Paralysis……... | No | Yes |
| Stroke…… | No | Yes |
| Head injury…… | No | Yes |

**PSYCHIATRIC**

| | | |
|---|---|---|
| Memory loss or confusion…… | No | Yes |
| Nervousness……. | No | Yes |
| Depression…… | No | Yes |
| Sleep problems…… | No | Yes |

**ENDOCRINE**

| | | |
|---|---|---|
| Grandular or hormone problem…… | No | Yes |
| Thyroid disease…… | No | Yes |
| Diabetes…… | No | Yes |
| Excessive thirst or urination…… | No | Yes |
| Heat or cold intolerance…….. | No | Yes |
| Dry skin……... | No | Yes |
| Change in hat or glove size……. | No | Yes |

**HEMATOLOGIC/LYMPHATIC**

| | | |
|---|---|---|
| Slow to heal after cuts……. | No | Yes |
| Easily bruise or bleed…….. | No | Yes |
| Anemia……. | No | Yes |
| Phlebitis…… | No | Yes |
| Past transfusion…… | No | Yes |
| Enlarged glands…… | No | Yes |

**ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reactions to:

| | | |
|---|---|---|
| Penicillin or other antibiotics…… | No | Yes |
| Morphine, Demerol or other narcotics.. | No | Yes |
| Novocaine or other anesthetics……. | No | Yes |
| Aspirin or other pain remedies……. | No | Yes |
| Tetanus antitoxin or other serums…… | No | Yes |
| Iodine, methiolate or other antiseptic… | No | Yes |

Other drugs/medications _____

_____

Known food allergies _____

Patient Signature: _____

Physician Signature: _____

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